



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEDICAL CENTER ER PHYSICIANS
PO BOX 4590 DEPT 6
HOUSTON TX 77210

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1177-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am filing a medical fee dispute for an unpaid bill for [injured worker] date of service 2/26/2010 in the amount of \$248.00. This bill was first filed to the patient's health insurance and paid on 3/17/2010. I received a refund request on 7/27/11 stating this visit was due to a work related injury. I filed the bill to the carrier that was provided on the refund request. Our office received a letter from Sedgwick requesting medical notes, the notes were faxed along with the letter and HCFA. On 10/5/11 I received a denied EOB for timely filing from Sedgwick, I mailed an appeal letter stating the insurance paid and requested a refund. I received a denied EOB from Sedgwick on 12/7/11 stating no additional reimbursement allowed. Attached is the HCFA, denied EOBs, appeal that was sent to Sedgwick, and refund request from Blue Cross Blue Shield."

Amount in Dispute: \$248.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor seeks payment of this medical bill in accordance with Texas Labor Code 408.272 as they filed their original claim with the Claimant's personal health insurance. However, Requestor accepted payment from the health insurance and has not refunded the money to that insurance company. Therefore, Requestor now seeks to gain a 'double payment' from the workers' compensation carrier which is not provided for in 408.0272. Additionally, Texas Labor Code 409.0091 allows the health insurance company to seek payment directly from the workers' compensation carrier if they feel that the treatments they paid for are related to a workers' compensation injury. In conclusion, this dispute was not timely filed and should be dismissed. Additionally, requestor's request for payment is not appropriate as they have received payment from another source and should not be allowed to receive a double payment."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan St., Ste. 4000, Dallas, tX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2010	CPT Code 99283	\$248.00	\$96.81

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §408.0272(c) sets out the procedure for health care providers seeking resolution from the carrier after submitting to the injured workers' private health care insurance.
3. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration of a medical bill.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 8, 2011 and October 18, 2011

- 29 – The time limit for filing has expired.
- 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
- 5094 – DWC requires request for reconsideration or corrected claims to be submitted within 11 months of the date of service.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Was the request for reconsideration made within 11 months in accordance with 28 Texas Administrative Code §133.250(b)?
3. Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code §408.0272(c) states that, notwithstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider's right to reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim. The requestor states they received written notification on July 27, 2011 from BlueCross BlueShield of Texas, letter dated July 14, 2011, requesting a refund of \$78.49 as benefits subject to worker's compensation are excluded under the limitations and exclusions sections of the injured workers private health care plan. The requestor further states that a bill was sent to the carrier on July 27, 2011; Sedgwick responded on August 16, 2011 stating they were unable to process the enclosed documents as the corresponding medical record was not attached for the date of service in question. According to the initial EOB Sedgwick received the bill September 8, 2011. Therefore the disputed date of service was timely filed and is eligible for review in accordance with 28 Texas Administrative Code §133.307 and the applicable fee guideline.
2. 28 Texas Administrative Code §133.250(b) states that the health care provider shall submit the request for reconsideration no later than eleven months from the date of service. Texas Labor Code §408.0272(c) allows a health care provider to submit to the correct workers' compensation carrier within 95 days following the date the health care provider is notified of the erroneous submission to the incorrect carrier. The reconsideration EOB documents the reconsideration request was received by Sedgwick CMS on September 8, 2011. This date is well within the 11 month timeframe required by rule.
3. Review of the submitted documentation finds that the requestor has met the requirements of the Labor Code and Administrative Code; therefore, reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$96.81.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$96.81 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May 2, 2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.